MAP-813D
(REV. 11/2018)

Cabinet for Health and Family Services Department for Medicaid Services

BREAST & CERVICAL CANCER TREATMENT PROGRAM
REQUEST FOR EXTENSION

RECIPIENT'S NAME: _____

RECIPIENT'S IDENTIFICATION #: _____

RECIPENT'S DATE OF BIRTH: _____/_____/_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

A. SHE IS RECEIVING TREATMENT FOR:

☐ BREAST CANCER

☐ CERVICAL CANCER

☐ PRECANCEROUS CERVICAL OR BREAST DISORDER

B. RECIPIENT'S MEDICAL AND TREATMENT HISTORY (PLEASE INCLUDE INDICATIONS AND RATIONALE FOR TREATMENT, I.E. PREVENTATIVE, CURATIVE, PALLIATIVE) AND WHY THE TREATMENT MUST CONTINUE.

_____

_____

_____

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_____

NEW TREATMENT END DATE: _____/_____/_____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

PHYSICIAN TELEPHONE #: (_____)_____-_____ FAX #: (_____) _____ - _____

Fax Completed form to 502-564-0039

AGENCY USE ONLY
MA END DATE HAS BEEN CHANGED TO: _____/____/_____

MEDICAID POLICY STAFF SIGNATURE: _____ DATE: _____

MEDICAID POLICY STAFF SIGNATURE: _____ DATE: _____